| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155777 | A. BUILDING 00<br>B. WING | 08/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CREASY SPRINGS HEALTH CAMPUS | 1750 S CREASY LN<br>LAFAYETTE, IN 47905 |

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| F0000 | This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on June 28, 2012.<br><br>August 15 & 16, 2012.<br><br>Survey team:<br>Michelle Hosteter, RN, TC<br>Michelle Carter, RN<br>Rita Mullen RN<br><br>Facility number : 012285<br>Provider number: 155777<br>AIM number : 201006770<br><br>Census bed type:<br>SNF: 45<br>SNF/NF: 18<br>Residential: 42<br>Total: 105<br><br>Census payor type:<br>Medicare: 32<br>Medicaid: 4<br>Other: 69<br>Total: 105<br><br>Sample: 9<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. | F0000 | The submission of this plan of correction does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the Residents of Creasy Springs Health Campus. The facilty maintains it is in substantial compliance with the requirements of participation for comprehensive health car facilities.This plan of correction will serve as the credible allegation of compliance with all federal and state requirments governing the management of this facility. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Quality review completed on August 22, 2012, by Bev Faulkner, RN | | | |

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| F0309<br>SS=D | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>Based on record review and interview, the facility failed to assess the change in conditions for a resident started on an antibiotic for a wound infection and a resident started on Pyridium for a spastic bladder. This effected 2 of 9 residents reviewed for assessments with a change of condition in a sample of 9. (Residents #36 & 48)<br><br>Findings include:<br><br>1. The clinical record of Resident #36 was reviewed on 8/16/12 at 11:00 A.M.<br><br>Diagnoses included, but were not limited to, dementia, depression and renal failure.<br><br>A Hospital Discharge instruction form, dated 7/16/12, indicated Resident #36 had under gone surgery for a fractured left hip.<br><br>A Physician's order, dated 7/30/12, indicated "Keflex [an antibiotic] 500 mg [milligrams] QID [four time a day] x 10 | F0309 | 1. Resident number 36: Resident was assessed and left hip incisions were noted to be resolved with no red or open areas observed. Resident number 48 was and continues to be assessed for bladder spasms and effectiveness of medication ordered to treat bladder spasms. 2. All Residents have the potential to be affected by this deficient practice. 3. Licensed staff will be inserviced on the following:a. Facility's policy and procedure for the proper documentation on the MAR and PRN assessment form when PRN meds are administered and for the proper documentation of the wound care sheet.b. Residents identified with impaired skin have been assessed and appropriate documentation completed. Residents receiving PRN medications will have a PRN medication tracking log utilized in conjuction with proper documentation on the medication administration record (MAR). 4. Medication adminstration records, PRN tracking logs and wound | 09/12/2012 |

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| | days (end on 8/9/12) and notify surgeon."<br><br>A Narrative Nursing note, dated 7/30/12 at 4:10 P.M., indicated "Notified [name of physician): redness, swelling @ incision sites et (and) order from (name of physician) was informed to watch site for [increased] s/s [sign and symptoms] of infection."<br><br>An "Infection Assessment and Review," dated 7/31/12, indicated "Wound left hip. Reddened wound periarea [around the wound]. Wound drainage. Wound periarea warm/hot to touch. Treatment required: yes. MD orders Keflex 500 mg QID x 10 days...." Follow- up on the form, consisted of check lists from 7/30/12 to 8/9/12 one box for each shift for a total of thirty check list boxes. The check lists indicated the following:<br><br>7/30/12 through 8/9/12: The recorded temperatures indicated Resident #36 was not running a fever.<br><br>Symptoms resolving: August 1, 2, 3, 4, 6, 7, 8/ and 9, 2012. There was no description of the wound regarding the amount of redness, drainage, swelling or pain. On August 5, 2012, the box for "Symptoms Resolving" was not checked.<br><br>Nursing "Skilled Nursing Assessment and | | skin sheets will be audited for accurracy 3 times a week for 4 weeks then weekly times 4 weeks then monthly times 4 months per the Director of Health Services and or designee. Audits will be reviewed monthly for 6 months in QAA commitee. | |

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| | Data Collection" form, dated 7/31/12, 8/2/12 and 8/7/12, (for a total of three forms filled out), indicated the skin was warm and dry, the color was natural, no skin impairment and had no dressing. There was no mention or description of the left hip wound nor was there an assessment of the wound after the antibiotic was completed on 8/9/12.<br><br>During an interview with the Director of Nursing, on 8/16/12 at 1:50 P.M., she indicated the wound sheets, which are kept in the wound/treatment book, would have a full description of the wound on Resident #36's left hip.<br><br>The "Wound/Treatment Book" was reviewed with the Director of Nursing, on 8/16/12 at 2:30 P.M. There were no wound sheets in the Wound/Treatment book. The Director of Nursing indicated the wound assessments should have been in the book.<br><br>2. The clinical record of Resident #48 was reviewed on 8/16/12 at 9:00 A.M.<br><br>Diagnoses for Resident #48 included, but were not limited to, neurogenic bladder, anxiety and insomnia.<br><br>A Physician's fax form, dated 7/27/12, indicated "Res [Resident] c/o [complaints | | | |

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| | of] bladder spasms (a contraction of the bladder sometimes accompanied by extreme pain) et [and] requests something PRN [as needed]." The Physician responded on 7/30/12, and ordered pyridium (an anti-spasmodic for the urinary tract) 200 mg po (by mouth) q (every) 8 (hours) PRN.<br><br>A review of Nursing notes, 7/27/12 through 8/9/12, did not indicated Resident #48 was having problems with bladder spasms.<br><br>A review of the "Skilled Nursing Assessment and Data Collection," dated 7/29/12 through 7/31/12, indicated Resident #48 was continent of bowel and bladder, used the toilet for elimination and the urine was yellow and clear. Bladder spasms were not addressed on the assessment.<br><br>A Physician's order, dated 8/1/12, indicated Pyridium 200 mg TID (three time a day) x 3 days then TID PRN.<br><br>A "Skilled Nursing Assessment and Data Collection," dated 8/1/12, indicated Resident #48 was "continent of bowel and bladder, had overflow of urine, used the toilet for elimination and the urine was clear and orange due the pyridium medication." Resident #48 complaint of | | | |

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| | not voiding. An In and Out catheterization collected 500 cc (cubic centimeters) of clear, orange urine. The bladder spasms were not addressed on the assessment.<br><br>An "Elimination Circumstance, Reassessment and Intervention" form, dated 8/1/12, indicated an I & O cath for a neurogenic bladder (causing an incontinence or retention of urine). The 72 hour follow-up form, consisted of check list boxes from 8/1/12 to 8/4/12; one box for each shift for a total of nine check list boxes. The check lists indicated the following:<br><br>8/1/12, 2 to 10 shift: Continent of bowel and bladder, I & O monitoring and no difficulty voiding.<br><br>8/2/12, 10 to 6 shift: Continent of bowel and bladder, I & O monitoring, no difficulty voiding and normal bowel movements.<br><br>No date or time on entry: I & O monitoring, 550 cc.<br><br>8/2/12, 2 to 10 shift: Continent of bowel and bladder, I & O monitoring and no difficulty voiding.<br><br>8/3/12, 10 to 6 shift: Continent of bowel | | | |

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| | and bladder and no difficulty voiding.<br><br>8/3/12, no shift indicated: Resident continent of bowel.<br><br>8/3/12, no shift indicated: The check list box was blank.<br><br>8/3/12, 2 to 10 shift: Continent of bowel and bladder, I & O monitoring and toileted with assist.<br><br>8/4/12, 10 to 6 shift: Continent of bowel and bladder, I & O monitoring, toileted with assist and pericare completed.<br><br>There was no documentation on the 6 - 2 shift on 8/4/12, regarding the neurogenic bladder. Bladder spasms were not addressed on the assessments.<br><br>A "Skilled Nursing Assessment and Data Collection," dated 8/5/12, indicated Resident #48 was continent of bowel and bladder, wore briefs, used the toilet for elimination and the urine was clear and orange due the pyridium medication. Bladder spasms were not addressed on the assessment.<br><br>A Medication Administration Record (MAR), dated for the month of August 2012, indicated Resident #48 had received pyridium 200 mg TID for | | | |

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| | bladder spasms routinely for three days starting on 8/1/12 with the evening dose and ending on 8/4/12 with the noon dose. Resident #48 received PRN doses on 8/10/12, 8/14/12 and 8/16/12. The back of the MAR indicated PRN medications were to have the reason given and results should be noted on Nurse's Medication notes. The back of the form was blank.<br><br>During an interview with LPN #1, on 8/16/12 at 3:00 P.M., she indicated PRN medications are documented on the PRN medication sheet and the assessments for the medication are done on the PRN sheet. The PRN medication sheet, dated for August 2012, was reviewed with LPN #1 on 8/16/12 at 3:10 P.M. The PRN sheet did not indicate Resident #48 had received pyridium 200 mg during the month of August 2012. There was no assessment regarding the use of pyridium for bladder spasms.<br><br>During an interview with the Director of Nursing on 8/16/12 at 1:00 P.M., she indicated the "Elimination Circumstance, Reassessment and Intervention" form, dated 8/1/12, was the bladder assessment. The resident had been on pyridium at the hospital and wanted to be back on the pyridium, that's why the physician wrote the order. | | | |

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| | This deficiency was cited on June 28, 2012. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-37(a) | | | |

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| F0371 SS=F | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br>Based on observation and interview, the facility failed to ensure shelving units were clean, hairnets were worn as required and proper food labeling and storage. These deficiencies had the potential to affect 92 of 92 residents who receive meals from the main kitchen.<br><br>Findings include:<br><br>During the main kitchen tour on 8/15/12 at 10:30 A.M., the following were found:<br><br>In the walk-in freezer: An open box (lid flaps not used) of 20 individual breaded pork loin fritters were found without a date of opening and were not covered.<br><br>In the walk-in refrigerator: Sixty (60) dishes of peaches and cottage cheese were found uncovered on trays and not dated. During an interview with the morning chef at this time, she said the dishes of peaches and cottage cheese were going to be served to residents at lunch that day (8/15/12). She indicated the food items needed to be dated and covered, but she | F0371 | 1. Areas cited during survey were cleaned on 8/16/12. Food not properly labeled was destoyed.2. All residents have the potential to be affected by this deficient practice.3. Entire kitchen was deep cleaned on 8/30/12 with direction and assistance of home office Dining Services staff. On 9/7/12, Dining Services home office support held a directed inservice for all dietary staff. Areas covered were kitchen sanitation and cleaning schedules, proper labeling and storage of opened food, and facility policy for wearing hair nets/hats in kitchen. All staff will be inserviced on hair net/hat policy by 9/12/12 by Dining Services home office support. Acting DFS, ADFS, closing chef, and dietician will audit kitchen sanitation by verifying cleaning tasks were completed Audits completed 5 days/ week.4. Dietician will review with QA&A committee results of audits/issues in dining services. | 09/12/2012 |

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| | had not had time to do so.<br><br>On 8/16/12, during an interview with the Director of Food Services (DFS) at 2:40 P.M., she indicated all opened items needed a date of opening and a label for contents. She indicated she was at a corporate event on 8/15/12, but the kitchen staff should have dated and labeled these items. She confirmed the main kitchen serves the health care residents and the assisted living residents.<br><br>During the main kitchen tour on 8/15/12 at 10:30 A.M., the following was observed: Four of 4 stainless steel shelves and counters were dusty and contained debris. The stainless steel shelf under the grill was dirty, sticky, and dusty. Four trash receptacles were found to be without lids in these areas: to the right of the grill, outside the walk-in freezer, at the east end of a stainless steel counter, and at the 2-compartment sink next to the handwashing station. At the time of the tour, these trash receptacles were not in use.<br><br>During the main kitchen tour, at 10:30 A.M., the morning chef was having a conversation with the Social Services Director (SSD). The SSD was not wearing a hair net. The two employees were standing 112 inches (9 feet, 4 | | | |

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| | inches) from the kitchen door.<br><br>During an interview with the DFS on 8/16/12 at 2:40 P.M., she indicated there was tape on the kitchen floor to determine how far an employee could go into the kitchen without wearing a required hairnet. The floor tape was measured and was found to be 56 inches (4 feet, 8 inches) away from the door.<br><br>The DFS, also, indicated that she had created a cleaning schedule for the cooks and dietary aides to follow. The cooks and aides were to make a handwritten checkmark next to the task listed after it was completed/cleaned. Additionally, she indicated some tasks were not completed/cleaned, as they should have been, according to the cleaning check lists from 7/30/12 to 8/12/12.<br><br>This deficiency was cited on June 28, 2012. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-21(i)(1)<br>5-5.1(f) | | | |

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| F0465 SS=D | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to ensure the floors of the main kitchen floors were clean and free of debris for 1 of 1 kitchen observed.<br><br>Findings include:<br><br>During the main kitchen tour on 8/15/12 at 10:30 A.M., the main kitchen's floor was not clean. Floors were dirty, dusty, sticky, with food crumbs and debris covered. There were noted milk droplets and clear fluid spillage.<br><br>In the dry storage room, the floor was sticky with noted, dirt, dust, grime and debris. | F0465 | 1. Kitchen floors were cleaned 8/16/12. 2. All residents have the potential to be affected by this deficient practice.3. Kitchen floors were deep cleaned on 8/30/12. Acting DFS, ADFS, closing chef, and dietician will audit kitchen sanitation and floor care/cleanliness by verifying floor cleaning schedules were followed. Audits completed 5 days/ week. Enviormental services will schedule kitchen floor deep cleaning quarterly4. Dietician will review with QA&A committee results of audits/issues in dining services, including floor care. | 09/12/2012 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREASY SPRINGS HEALTH CAMPUS | 1750 S CREASY LN<br>LAFAYETTE, IN 47905 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | On 8/16/12, during an interview with the Director of Food Services (DFS) at 2:40 P.M., she indicated new floor cleaning products were ordered but had not arrived, yet. Additionally, she (the DFS) indicated she created a cleaning schedule for the cooks and dietary aides to follow. Floor cleaning (mopping and using a deck brush) was included on the schedule. The cooks and aides were to make a handwritten checkmark next to the task listed after it was completed/cleaned. Additionally, she indicated some tasks were not completed/cleaned, as they should have been, according to the cleaning check lists from 7/30/12 to 8/12/12. She confirmed the main kitchen | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155777 | A. BUILDING 00<br>B. WING | 08/16/2012 |

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| CREASY SPRINGS HEALTH CAMPUS | 1750 S CREASY LN<br>LAFAYETTE, IN 47905 |

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|---|---|---|---|---|
| | serves the health care residents and the assisted living residents.<br><br>3.1-19(f)<br>5-1.5(k) | | | |
| F9999 | | F9999 | No information has been provided for this area. All previous citations other than 2 were cleared. I am responding only because I am unable to close and submit if I did not. | 09/12/2012 |